Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (•) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Incident Management Policy and the DDP Incident Management System handbook is the reference source providing the following information. Reporting requirements are references in Montana Codes Annotated and the Administrative Rules of Montana, below.

53-20-205 MCA, 52-3-801 through 52-3-825 MCA, 53-20-163 MCA, 53-20-163 MCA
ARM 37.34.1501 through 37.34.1513

Reportable Incidents need to be submitted in writing to the DDP CM & QIS within 2 days.
Critical Incidents need to be reported to: DDP CM – as soon as possible, within 8 hrs: DDP QIS – within 8 hrs & Guardian as soon as possible and an IR form. Any actual or suspected abuse, neglect or exploitation is required to be reported: as soon as possible, within 8 hrs to APS.
(Adult Protective Services); for residents of group homes or licensed foster homes, also report to licensing as soon as possible, within 24 hrs.

ALLEGATIONS OF ABUSE, NEGLECT, OR EXPLOITATION:

Incident – TYPE Abuse
Reportable any actual or suspected
Critical Any actual or suspected, includes consumer to consumer

Incident – TYPE Emotional / Psychological (verbal) Abuse
Reportable ridicule, humiliate, scorn, dehumanizing, manipulative, denigrating, socially stigmatizinging, fail to respect dignity of individual.

Critical same as reportable and any actual or alleged consumer to consumer incident

Incident – TYPE Financial/Material Exploitation
Reportable items less than $49.99
Critical greater than $49.99 per incident or over (total in 30 days)

Incident – TYPE Mistreatment
Reportable contra-indicated by IP; not follow accepted treatment practices/standards of care; use of specific behavior procedures
Critical same as reportable and any actual or alleged consumer to consumer incident

Incident – TYPE Neglect

Reportable insufficient, inconsistent, inappropriate services, treatment or care
Critical same as reportable and any actual or alleged consumer to consumer incident

Incident – TYPE Physical Abuse
Reportable physical contact not for the safety of the individual
Critical same as reportable and any actual or alleged consumer to consumer incident

Incident – TYPE Sexual Abuse
Reportable sexual assault, sexual intercourse w/o consent, indecent exposure, deviate sexual conduct, incest
Critical same as reportable and any actual or alleged consumer to consumer incident

Incident – TYPE Aspiration/ Choking
Reportable individual is able to clear airway w/o intervention
Critical airway is cleared with any assistance from staff or medical intervention

Incident – TYPE Death
Reportable any loss of life
Critical same as reportable

Incident – TYPE Illegal/Hazardous Substance
Reportable prohibited/illegal/IP team approval (must have signed Rights Restriction w/IP)
Critical law enforcement reporting required

Incident – TYPE Hospitalization
Reportable unplanned visit to hospital, Emergency Room, 1st Care/Fast Track, or physician
Critical unplanned admit for surgery, observation, treatment, testing, psychiatric, notify CM, QIS and RM asap

Incident – TYPE Medication Error
Reportable capacity to cause harm due to nature of what occurred *see definition list in Policy
Critical serious adverse effect; life, health, welfare in jeopardy; treated at ER/clinic; hospitalized

Incident – TYPE Missing Person
Reportable elopement attempt when individual at risk if unsupervised or places others at risk
Critical search procedures initiated; absence of any duration if poses immediate danger

Incident – TYPE Injury
Reportable requiring treatment greater than standard1st aid, * see definitions in Policy
Critical treatment from medical professional

Incident – TYPE Property Damage
Reportable exceeds $50
Critical exceed $200 and/or 3 month period over $200

Incident – TYPE Mechanical Restraint
Reportable device that restricts movement
Critical prohibited device

Incident – TYPE Physical/Manual Restraint
Reportable physical/manual intervention that restricts movement
Critical any prohibited physical or manual practice; use of restraint w/no Level II Plan

Incident – TYPE PRN Medication
Reportable any prn medications used to control behavior problem
Critical psychotropic PRN; PRN meds w/o approved protocol

Incident – TYPE Exclusion Time-out
Reportable requiring person to leave a reinforcing situation due to behaviors
Critical exclusion time-out with no Level II plan

Incident – TYPE Seclusion Time-out

Reportable use of a time-out room/closed door
Critical seclusion time-out with no Level II plan

Incident – TYPE Rights Violation
Reportable any violation without an approved right's restriction * see definition list in Policy
Critical same as reportable

Incident – TYPE Seizure
Reportable Optional: minor or potential injury
Critical any seizure resulting in physical injury, or emergency medical intervention

Incident – TYPE Self-Injurious Behavior (SIB)
Reportable injury or potential injury/harm
Critical assessment/treatment by medical professional; emergency behavior support procedures

Incident – TYPE Suicide Threats or Attempt
Reportable there are no reportable
Critical attempt/act to harm, injure, or kill self; includes threats (verbal, non-verbal, written

Incident – TYPE Ingestion of harmful substance (PICA)
Reportable non-food/potentially threat to health
Critical medical assessment or treatment by medical professional

Incident – TYPE Law Enforcement
Reportable contact with law enforcement
Critical contact involves force or restraint; custody; ticket, citation, or charge

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Adult Services

The responsibility of providing this information to recipients currently rests with service providers and with case managers. The DDP adult services system has offered abuse prevention training on a limited basis to providers for several years via QIS's who have been trained in the MacNamara Abuse Prevention Curriculum and certified as Abuse Prevention Specialists. These instructors offer two primary services to providers:

1. Training in recognizing the signs and symptoms of abuse, and techniques in providing emotionally responsible care giving.
2. Assessment of care giving environments, for the purpose of developing recommendations designed to reduce the potential for abuse.

Direct training to recipients regarding abuse reporting may occur for some individuals based on potential for risk, but there is no formal statewide effort to provide this information to recipients at this time.

Some protections are afforded via the annual PSP Interview/Consumer Survey. Case Managers currently ask open-ended questions, e.g., are you ever afraid of anyone or anything? Do people treat you with respect? Do you ever feel left out or neglected? Who do you talk to if you don't like someone or are having problems with someone? The answers would lead to follow up by the case managers in the event problems are identified.

The DDP will integrate specific questions in the PSP Interview/Consumer Survey serving to assess the skills of recipients in reporting incidents when situations involving abuse, neglect or exploitation may have occurred. Any noted skill deficiencies will result in follow up by the case manager.

DDP adult QA consumer survey questions will be updated to incorporate the PSP Interview/Consumer Survey questions and the QIS will follow up, as needed, when deficiencies are noted based on the consumer responses.

The consumer surveys will be updated and will become effective 7/1/08.

In addition to recipient feedback gained during the Pre-IP and on site DDP QA process, provider staff will be asked

if the corporation provides training to recipients on issues of abuse, neglect and exploitation and reporting procedures as part of the DDP QA onsite review process. If no formal training is provided, provider follow up will be requested in the QA Report. This process will be implemented effective 7/1/08.

Children's Services

In children's services, parents or foster parents are the primary care givers. Child and Family providers are responsible for training staff and families in abuse prevention. One provider currently provides an abuse information sheet with some training to parents and foster parents. This document gives care givers information on recognizing the signs and symptoms of abuse and neglect. An abuse reporting hotline number is included on this document. A copy of this document (considered a best practice) is available from the Department upon request. Effective 7/1/08, The DDP QA process for child and family services will assess the current abuse the abuse prevention training efforts of non-certified staff for the purpose of Department follow up, if needed.

Abuse Prevention Training has been provided to Child and Family service provider staff on a limited basis by DDP QIS's certified as Abuse Prevention Specialists in the MacNamara curricula.

The DDP QA consumer satisfaction survey used for families will be upadated to include questions serving to assess family knowledge of reportable incidents and the process for reporting. If training is needed, follow up would take place via the Family Support Specialist. This process will become effective 7/1/08.

In addition to recipient feedback gained during the Pre-IP and on site DDP QA process, the Family Support Specialist will be asked if the corporation provides training to recipients on issues of abuse neglect and exploitation and reporting procedures as part of the DDP QA onsite review process. If no formal training is provided, provider follow up will be requested in the QA Report. This process will be implemented in the C&F QA process and become effective 7/1/08.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Space limitations in Section C preclude insertion of the incident management reporting protocols of DDP's Incident Reporting Policy. The table may be reviewed at the DDP website and is also available in the hard copy of the 0208 Waiver Amendment, effective 7/1/06. Access to the website follows
http://www.dphhs.mt.gov/dsd/mt020890waiver/appendixg.pdf

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The details involving the oversite activities may be reviewed in Appendix B of the Incident Management Policy and the DDP Incident Management System. In brief, the following applies.

The Incident Management System policy requires the compilation of data by region, by corporation and by individual.

Overview of the provider specific incident information occurs at scheduled weekly service provider meetings (can be cancelled if no incidents occurred) of the State Qualified Provider Incident Management Committees. The purpose of these meetings is to ensure that efforts are made to reduce the likelihood of similar incidents occurring in the future. The case managers for recipients served by the provider are required to attend these weekly meetings. In addition, a DDP QIS, the provider Incident Management Coordinator, the Director or his designee and representatives of the provider's operational program units will attend the weekly meetings.

The provider is responsible for submitting a monthly Incident Management Trend Summary of Critical Incidents report to the provider Board of Directors, Human Rights Committee and Quality Improvement Specialist. In addition, a provider annual report must be submitted to the same individuals summarizing the committee reviews and the actions taken.

Overview of this information at the DDP central office level includes a designated staff person reviewing the results of all critical incident investigations, and providing technical assistance to persons and agencies involved in the investigations.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

The State does not permit or prohibits the use of restraints or seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Note- ARMs outlining conditions for the use of restrictive procedures have been applied to adult services and children's group home settings. Restrictive procedures used by child and family service providers in natural homes are based on the desires of the parent and agreed upon by the child's planning team. Restrictive procedures are considered procedures of last resort, in the children's and adult service systems.

Adult services:

The use of restraints and time out is governed in accordance with ARM 37.34.1401 through 37.34.1428, except the use of medications to control behavior is not governed under these rules.

Medications may be used in accordance with the review of the IP team and the individual's physician or psychiatrist. The CMS review findings related to the use of psychotropic medications as outlined in the CMS final review report dated 4/01 resulted in the following:

1. Development, distribution and provider training in the Psychotropic Medications Reference Guide: A Companion Guide for use by Providers of Developmental Disabilities Services in Montana, written by Dr. William Docktor.

2. A DDP contract was initiated with Dr. Robert Caldwell, Psychiatrist, offering no-cost telephone consultation services to any person involved in serving a person with a developmental disability.

Physical and mechanical restraint, and seclusion time out procedures are considered interventions of last resort. Their use as either emergency procedures or as part of an ongoing behavior program is outlined in the previously referenced ARMs. These procedures may be used on an ongoing basis only when reviewed and approved by the Developmental Disabilities Program Review Committee (DDPRC). The DDPRC Standard Operating Procedures policy governs the disposition, scope, and authority of the committee. The DDPRC Guidelines for Level II Programs defines the contents of a referral packet when a provider is seeking to implement a Level II procedure.
Use of emergency procedures employing restraint or time out is subject to the requirements of ARM 37.34.1420.

37.34.1420 AVERSIVE PROCEDURES: EMERGENCY PROCEDURES
(1) Emergencies are those situations for which no approved individu¬al program plan exists and which if not dealt with may result in injury to the client or other persons or significant amounts of property destruction.
(2) If an emergency occurs the service provider may apply the following techniques as necessary to

bring a person's behavior under control:
(a) Physical restraint;
(b) Exclusion time-out; or
(c) Seclusion time-out in a room that conforms to the minimum requirements established by the developmental disabilities program review committee (DDPRC) and, that has been approved by the regional manager prior to use.
(3) All instances of the use of emergency procedures must be reported, in writing, to the regional manager within 48 hours. Such reports shall include at a minimum the time and date of the incident, the persons involved, the type and dura¬tion of the incident, a description of the cause(s) leading to it, any witnesses to the incident, the procedures employed, and other significant details. If an emergency procedure is used three times in a 6 month period, a written individual program plan must be developed. (History: Sec. 53 2 201 and 53 20-204, MCA; IMP, Sec. 53-20-203 and 53-20-205, MCA; NEW, 1986 MAR p. 345, Eff. 4/21/86; AMD, 1993 MAR p. 1356, Eff. 6/25/93; TRANS, from SRS, 1998 MAR p. 3124.)

In addition to the applicable rules, the Incident Management Policy and DDP Incident Management System outlines the provider and State staff reporting and investigation responsibilities when mechanical restraint, physical or manual restraint, PRN medications, seclusion and exclusion time out is used.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The use of restraints or seclusion time out fall broadly into two categories; use as emergency procedures and use in approved behavior support plans.

Emergency Use

Providers are responsible for reporting the incidents as outlined in the Incident Management Policy and in the ARMs governing the use of these procedures. The DDP QIS and the provider are responsible for tracking the frequency of emergency procedures and complying with the requirements set forth ARM 37.34.1420 (see previous section). The ongoing use of emergency procedures requires the ongoing involvement of the planning team, and potentially, the development of an approved behavior support plan to address the behavior requiring the use of the emergency procedures.

Compliance with reporting policy and rule is assessed as part of the QA onsite interviews with staff as outlined in Appendix I of the DDP Quality Assurance Process. In addition to staff interviews, onsite visits as outlined in Appendix E of the QA process serve as an additional safeguard.

Approved Behavior Support Plans

Any proposed use of physical, mechanical, exclusion or seclusion time out is contingent upon the initial approval of the recipient's planning team. Support programs employing Level II programs as defined in ARM 37.34.1410 require the initial and ongoing approval of the Developmental Disability Program Review Committee (DDPRC) as outlined in the previous section. Staff must be certified prior to the implementation of the behavior support plan. Certification is contingent upon staff demonstrating competence in the procedures and correctly answering oral questions pertaining to the support plan. The DDPRC may remand approval authority for level II programs to the DDP Regional Manager.

Compliance with the incident reporting policy and the aversive rule is assessed as part of the QA onsite interviews with staff as outlined in Appendix I of the DDP Quality Assurance Process. A sample of staff providing direct services to individuals with behavior support plans are selected to answer oral questions and demonstrate the procedures used in these plans. In addition to staff interviews, onsite visits as outlined in Appendix E of the QA process serve as an additional safeguard.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Note- ARMs outlining conditions for the use of restrictive procedures have been applied to adult services and children's group home settings. Restrictive procedures used by child and family service providers in natural or foster homes are based on the needs and desires of the parent or surrogate parent, and agreed upon by the child's planning team. Restrictive procedures are considered procedures of last resort in both children's and adult services.

Safeguards governing the use of client rights restrictions, non-aversive, level I and level II procedures are outlined in ARM 37.34.1401 through 37.34.1428. Level 1 procedures are less restrictive than level II procedures, but may not be used unless approved by the planning team. A formal written plan is required. Examples of level I procedures include contingent observation, restriction of social activities and educational finds, as outlined in 37.34.1410.

Client rights may be restricted under the provisions set forth in rule. Any imposition of restriction of a client right requires the initial approval of the planning team. Client right restrictions are defined by ARM 37.34.1404 as follows:

"Restriction of rights/privileges" means procedures which involve withdrawal, delay, or curtailment of rights or privileges which a person may ordinarily exercise. Such withdrawal is usually in connection with a program through which the person may exercise such rights and/or privileges by performing specified behaviors.

Some rights may not be restricted under the provisions set forth in ARM 37.34.1418. Any ongoing use of a client rights restriction requires the ongoing approval of the planning team, and the team may recommend the development of a formal planning action, designed to reduce or eliminate the need for the rights restriction. This decision would be based on the nature of the restriction and other factors. In adult services, The Restriction of Personal Rights Form lists the conditions to be considered when a rights restriction is proposed. These are as follows:

1. Describe the restriction:

2. What is the reason for this restriction? (Include assessment data documenting the problem.)

3. What will be the consequences of not imposing this restriction?

4. What action will be taken to remove the need to this restriction? (e.g., What training/ support will occur?)

5. Under what condition(s) will this restriction no longer be necessary?

6. When will the need for this restriction no longer be necessary?

7. Is this the least restrictive intervention? (Provide documentation of prior intervention)

Any proposed procedures not classified by rule must be submitted to the DDPRC for classification as either a non aversive, a level I or a level II procedure, as outlined in ARM 37.34.1428. The procedure may be used only in accordance with the rules governing the classified procedure.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The same protections outlined in G-2.c.i. (above) apply, except the DDPRC would not be involved in the review or the approval of procedures classified as non-aversive or level I.

In addition to protections afforded by the formal review of data for behavior support plans as outlined in rule, and the incident management policy (including the compilation and review of data by the incident management committees), the DDP QIS also reviews staff competence in oral interviews with sample staff during on site portion of the annual QA review. Specifically, staff are asked questions about client rights, rights restrictions, and behavior support plans/aversive procedures, as outlined in Appendix I of the Quality Assurance Process. If problems are noted in the staff responses, the QIS may recommend additional staff training in these areas.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The interpretation given for "second line guidance" on page 215 of the V3.3 instruction guidelines refers to monitoring practices not applicable to the 0208.90.R2 Waiver.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

N/A. See above.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

i. **Provider Administration of Medications.** *Select one:*

Not applicable. *(do not complete the remaining items)*

- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Non- medical professionals may assist and supervise in the administration of medications under a DDP agreement with the Montana State Board of Nursing. Staff providing medication assistance to individuals must be "med certified" in accordance with the provisions of ARM 37.34.114 (also known as the "med rule"). Staff are "med certified" on the basis of passing a written test covering topics such as the purpose and use of various medications, administration "do's and don'ts", requirements for record keeping and proper storage, and responsibilities related to follow up in the event of med errors. The curriculum used to impart skills to staff is Managing Medications in Developmental Disabilities Program-Funded Services: A Self-Paced Instructional Manual written by Dr. William Docktor. This manual and medication certification process was approved by the Montana Board of Nursing. Staff must demonstrate proficiency in the curriculum by taking and achieving a passing score on the med test every two years. DDP staff administer the medication tests.

The med rule requires the implementation of a training objective(s) if a person is not independent in the self-administration of meds, and the conditions under which this requirement can be waived.

The med rule applies to all staff in DDP waiver funded services, including those staff providing services to adults and children living with their natural families, and in foster care. There have been numerous requests for interpretations of med rules and DDP policy statements over the years. The answers to these requests for clarification are shared statewide with all providers and copies of these documents are available upon request from the DDP.

iii. **Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The DDP The Incident Management Policy and DDP Incident Management System outlines the service provider responsibilities based upon the classification of the med error (reportable or critical), required content of the report, the reporting requirements relating to agencies to be notified and the required time frames.

Reportable Incidents- Reportable incidents are defined on page 3 of Appendix A of the policy. Reportable incidents include any medication or treatment error resulting in a situation where a consumer evidences, or could potentially experience, marked adverse side effects. A medication error is classified according to severity utilizing guidelines recommended by the National Coordination Council for Medication Reporting and Prevention. Examples of medication errors may be reviewed in section (b) below. Additional detail is available on pages 2 and 3 of Appendix A of The Incident Management Policy and DDP Incident Management System.

The service provider identifying a reportable incident and initiating an incident report (IR) form must notify the recipient's case manager and QIS within 2 working days by submitting a copy.

Critical Incidents- Reportable medication error incidents are classified as critical incidents when the following conditions occur relative to the various forms of medication errors.
- The recipient experiences serious side effects.
- The recipient's life, health or welfare is in jeopardy due to an action or inaction.
- The recipient is treated at a hospital emergency room or a medical clinic.
- The recipient is admitted to a hospital.

Critical medication errors must be reported to the QIS, case manager, guardian or next of kin, and DPHHS licensure bureaus for recipients in foster care or group homes in accordance with the time frames specified in Appendix C. In addition, critical incidents will be investigated as outlined in the incident management policy

(b) Specify the types of medication errors that providers are required to *record:*

The general categories of med errors outlined in the Incident Management Policy include the following: Physician or pharmacy error, incorrect administration, omission/missed dose, wrong time, unauthorized dose, training and documentation errors and "other" for med errors not classified in these categories. Specific examples of med errors falling within these categories may be reviewed in Appendix A of the policy.

(c) Specify the types of medication errors that providers must *report* to the State:

All medication errors must be reported to the DDP. In addition, all medication errors must be reported to the recipient's case manager.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

In addition to involvement in the investigations involving critical medication errors, the DDP QIS is also involved in monitoring medications as part of the DDP quality assurance process. This includes reviewing medication storage, medication documentation in the med logs, reviewing the qualifications of staff assisting with medications (medication certification must be current). In addition, a sample of direct care staff must demonstrate competence in correctly answering oral interview questions regarding medications and procedures. Appendix I of the QA process provides an overview of the questions relating to the medication requirements outlined in ARM 37.34.114 and the incident management policy. Appendix E references the medication review checklist items for the QIS onsite visits. All adult services residential sites are visited once per year and the adult and children's congregate living and adult congregate work/day sites are visited once per quarter.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation. DDP is currently developing an abuse prevention curriculum designed to: 1. Assess client knowledge and, if appropriate, teach the individual the necessary skills to recognize and report abuse. 2. Train adult case managers to recognize the signs/symptoms of abuse.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Training record reviews for case managers, and reviews of the records of client abuse awareness/reporting assessments and subsequent training, if appropriate.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = To be developed
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The incident reporting system is web based, and the data can be sorted and summarized to give reviewers information on critical incidents in accordance with the desired need of decision makers. Provider compliance in fully complying with the incident reporting policy varies; increases in the number of reported critical incidents could be interpreted to mean increasing problems within an agency, or increased cooperation by the agency in complying with the incident reporting requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The outcomes of the incident management committee meetings are documented in meeting minutes. These minutes are forwarded to the DDP field offices and the DDP central office. The purpose of these meetings is to enable providers to meet with representatives from case management and the Department to develop solutions serving to reduce or ameliorate the health/safety risks within each agency.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The Department will implement a fully compliant Version 3.5 data summary methodology for this section effective 7/1/10.